



CHALLENGING COMPULSORY ADMISSION TO HOSPITAL UNDER THE MENTAL HEALTH ACT 1983:

DOES THE LAW ADEQUATELY PROTECT THE RIGHT TO LIBERTY?

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**Winner Nash and Co Solicitors Best
Graduate Diploma in Law Prize 2010**

Abstract

The Mental Health Act 1983 provides for compulsory admission to hospital, under criteria designed to ensure individuals are not detained wrongly. This article examines the primary legal means by which compulsory admission can be challenged. Habeas corpus and judicial review offer means of examining the legality of a decision, based on the decision-making procedure. The efficacy of these mechanisms in mental health cases has come under scrutiny from the European Court of Human Rights. The Mental Health Review Tribunal conversely is equipped to examine legality based on the merits of the decision. The potential for conflict here, however, lies in the relationship between the medical and the legal approaches to addressing mental health issues. Interpretations and perceptions of 'human rights' are central to this topic and pervade this discussion.

Keywords: Mental Health Act 1983, Mental Health Review Tribunal, compulsory detention, habeas corpus

Introduction

The right to personal liberty is enshrined in English common law.¹ However, in certain circumstances under the Mental Health Act (MHA) 1983, individuals can be detained in hospital against their will. Given the gravity inherent in depriving someone of his/her liberty, it is crucial that proper safeguards exist to ensure that such detention is both necessary and just. This article will examine these safeguards. Following an outline of

¹ The principle that the state may not interfere with an individual's personal liberty except where the law permits is affirmed in cases such as *Entick v Carrington* (1765) 19 State Tr 1029.

the provisions to detain a person under the MHA, it will discuss the mechanisms by which the legality of the procedures can be challenged, specifically the writ of habeas corpus and judicial review. It will then move beyond procedural challenges to explore those founded on the merits of a case, brought through the Mental Health Review Tribunal. The discussion of the mechanisms to challenge compulsory detention highlights the tensions at the heart of this area of law: the need to balance the interests of society with the rights of the individual and the respective weight attached to the differing standpoints of doctors and lawyers.

1 Compulsory Admission to Hospital under the Mental Health Act 1983

There are a number of provisions for compulsorily admitting patients to hospital under the MHA, pertaining to a range of circumstances. Section 2 provides for admission for the purposes of assessment for a period of 28 days or under.² Section 3 provides for admission for treatment, in the first instance for a period not exceeding six months, renewable for a further six months upon expiration of this first period, and thereafter for a year at a time.³ Section 2 is the most commonly used section to detain patients.⁴ It gives an opportunity for initial assessment prior either to the enforcement of a lengthier admission period (under s.3) or to discharge. There are further provisions for compulsory detention under other circumstances. These include: admission for up to 72 hours for assessment in an emergency (s.4); admission following a police officer removing a person from his/her home on the basis that he/she is being ill-treated (s.135); and admission following an officer finding a sufferer of a mental illness in a public place in need of immediate care (s.136). The vast majority of admissions are made under sections 2, 3 and 4.⁵

An application for admission under s.2 will usually be made by an approved mental health professional, but can be made by the patient's nearest relative. The mental health professional must interview the patient and satisfy him/herself that the criteria for detention are fulfilled and that the course of action is the most appropriate for the

² Mental Health Act (MHA) 1983, s.2(4).

³ s.3 and s.20(1)-(2).

⁴ Mind, 'Statistics 4: The Mental Health Act 1983', http://www.mind.org.uk/help/rights_and_legislation/statistics_4_the_mental_health_act_1983, 24 March 2010.

⁵ Mind, 'Statistics 4: The Mental Health Act 1983' states that in 2007-08, 95 per cent of non-voluntary admissions to NHS facilities were under Sections 2, 3 and 4.

patient.⁶ The criteria are: that the patient is suffering from a mental disorder of a nature or degree that warrants detention in hospital for assessment;⁷ and that the patient should be detained in the interests of his/her own health and safety or for the protection of others.⁸ Applications must be founded on written statements of two medical practitioners attesting that these conditions are fulfilled.⁹ The provisions for admission under s.3 are similar, but with some notable differences. The patient's condition must warrant detention in hospital for medical *treatment*, and detention under s.3 must be the only way for him/her to receive such treatment.¹⁰ Furthermore, the patient cannot be detained under s.3 unless appropriate medical treatment is available for him/her in the hospital.¹¹ The mental health professional cannot make an application under s.3 if the patient's nearest relative has objected to this course of action,¹² and the mental health professional has an obligation to consult the nearest relative unless it is not reasonably practicable.¹³

2 Habeas Corpus

The writ of *habeas corpus ad subjiciendum* is a prerogative process with its roots in the common law dating back many centuries. It effects the principle that the Sovereign can inquire into the legality of the detention of any of his/her subjects, and order a release if this legality is not established. It is thus able to address the enacting of procedures, but not the merits of a case. Someone released under habeas corpus is not acquitted, nor – in the case of a patient – are the medical grounds on which he/she was detained called into question.

*R v Turlington*¹⁴ and *Re Shuttleworth*,¹⁵ habeas corpus cases of the eighteenth and nineteenth centuries respectively, illustrate that the remedy has long been utilised by those detained for reasons of mental ill health. In *Re S-C*,¹⁶ Sir Thomas Bingham affirmed that habeas corpus is an appropriate remedy when statutory procedures for

⁶ MHA 1983, s.13(2).

⁷ s.2(2)(a).

⁸ s.2(2)(b).

⁹ s.2(3).

¹⁰ s.3(2)(a) and (c).

¹¹ s.3(2)(d).

¹² s.11(4)(a).

¹³ s.11(4)(b).

¹⁴ *R v Turlington* (1761) 97 ER 741.

¹⁵ *Re Shuttleworth* (1846) 115 ER 1423.

¹⁶ *Re S-C* [1996] QB 599, at 612.

detaining a patient under the MHA have not been properly fulfilled. Its potency lies in its scope for restoring the patient's liberty immediately without the need for a lengthy exploration of the merits of the detention.

Furthermore, applications for habeas corpus allow the courts to underline the gravity of the requirements in the MHA, potentially improving professionals' practice in a more robust manner than an internal complaints procedure might.¹⁷ Despite the appropriateness of habeas corpus in this context being doubted in *B v BHB Community Healthcare NHS Trust*,¹⁸ applications continue to be made and judgments – particularly in the field of nearest relative consultation – continue to emphasise the need to follow procedure properly. *BB v Cygnet Health Care*¹⁹ concerned a challenge to a s.3 detention based on the social worker's failure to consult the nearest relative as required by s.11(4). The social worker consulted the patient's sister, whereas the father, whose English was poor, was in fact the nearest relative. The sister's assertions should have put the social worker on notice that the nearest relative was likely to object. In assessing the application for the writ, the court upheld the exacting standards for fulfilment of the consultation process, adhering to the assertion of Otton LJ in *Re D*²⁰ that s.11 must be 'construed strictly [as] it involves the liberty or loss of liberty of a person.'²¹ The application for habeas corpus in *GD v Edgware Community Hospital and London Borough of Barnet*²² similarly gave the court the opportunity to stress the exacting standards required for fulfilment of s.11. Here the social workers sought to rely on the provision in s.11(4)(b) that they are only obliged to consult the nearest relative if it is reasonably practicable. It was found, however, that they had 'set in motion a course of events which was designed to leave consultation with GD's father to the very last moment' which 'seriously inhibit[ed] the chances of his having [...] an opportunity to

¹⁷ Davidson raises concerns about the 'avoidant' social worker with regard to proper adherence to the MHA in Davidson, L., 'Nearest Relative Consultation and the Avoidant Mental Health Professional', (2009) Spring *Journal of Mental Health Law* 70. Bartlett and Sandland fear that the regulations are considered 'tiresome bureaucratic requirements that are a source of irritation' for the professionals: Bartlett, P. and Sandland, R., *Mental Health Law: Policy and Practice* (2003, 2nd ed. Oxford University Press), p.235.

¹⁸ *B v BHB Community Healthcare NHS Trust* [1999] 1 FLR 106.

¹⁹ *BB v Cygnet Health Care* [2008] EWHC 1259 (Admin).

²⁰ *Re D* [2000] 2 FLR 848.

²¹ *Ibid.* at [15].

²² *GD v Edgware Community Hospital and London Borough of Barnet* [2008] EWHC 3572 (Admin).

make an objection'.²³ The words of Bennett J in *R v Bristol CC ex parte E*²⁴ – that the nearest relative's role is 'not lightly to be removed by invoking impracticability' – were put into effect.²⁵

Habeas corpus was criticised by the European Court of Human Rights (ECtHR) in *X v United Kingdom*²⁶ for lacking the scope to consider the merits of a case. The case concerned an offender who was detained in a mental hospital upon conviction, conditionally discharged some years later, then recalled to hospital some years after that under the MHA 1959, s.66. The Act in its 1959 incarnation no longer applies, but the court's assessment of habeas corpus remains relevant. X contested that his recall to hospital and unsuccessful attempt to secure release through habeas corpus constituted a breach of the European Convention on Human Rights (ECHR), Art.5(4). This gives a person deprived of his/her liberty entitlement to have the lawfulness of his/her detention decided speedily by a court and his/her release ordered if the detention is not lawful. *Prima facie* habeas corpus seems to address precisely this entitlement. The ECtHR held, however, that whilst a domestic court considering a habeas corpus application could determine that 'detention was 'lawful' in terms of English law, this cannot of itself be decisive as to whether there was sufficient 'lawfulness' for the purposes of Article 5(4).' The judgment of the ECtHR went on to state that habeas corpus deals with 'compliance with the requirements stated in the relevant legislation', whereas a mechanism fit to fulfil Art.5(4) should:

be wide enough to bear on those conditions which, according to the Convention, are essential for the 'lawful' detention of a person on the ground on unsoundness of mind.²⁷

Specifically, it should be able to examine whether the conditions under which the patient was detained still apply. This goes further than simply demanding an assessment of the merits of the case as they were when detention was enforced, to demanding an assessment of the merits of detention as they are presently. The requirement highlights

²³ Ibid., at [51].

²⁴ *R v Bristol CC ex parte E* [2005] EWHC 74 (Admin).

²⁵ Ibid. at [29].

²⁶ *X v United Kingdom*, (1982) 4 EHRR 188.

²⁷ Ibid. at 209.

the sanctity of the freedom of the individual and makes it clear that a procedure-based remedy alone is insufficient to safeguard human rights.

3 Judicial Review

The decisions of doctors and social workers in compulsory admission proceedings are, the High Court has established, subject to judicial review.²⁸ In *B v BHB Community Healthcare NHS Trust*,²⁹ Lord Woolf MR indicated that there are few significant differences, procedurally and in terms of outcome, between habeas corpus and judicial review. He does, however, assert that judicial review is a more appropriate course of action in challenging detention in the mental health context, citing cost efficiency and a greater range of remedies including damages.³⁰ Other features of judicial review impact on its appropriateness in this context. These are discussed below.

Judicial review is, like habeas corpus, a remedy on which the test of the legality of a decision is founded on procedural grounds. It has a wider scope than habeas corpus as it is able to examine factors other than merely a failure to adhere to due process. These include an overly rigid approach to policy, consideration of irrelevant factors, failure to consider relevant factors, and unreasonableness. In theory, an application for compulsory hospital admission which adhered to the procedural requirements of the MHA but which was based on irrelevant factors or an overly rigid fettering of discretion could not be challenged on the grounds of habeas corpus. Judicial review, however, provides the scope for challenging such an admission.

It has been argued that the jurisdiction to consider unreasonableness in judicial review enhances the mechanism's potency as a safeguard against unlawful detention.³¹ The level of unreasonableness required for judicial review to intervene has been described variously as: irrationality,³² a taking leave of senses,³³ or leading to a decision so 'outrageous in its defiance of logic or of accepted moral standards that no sensible person who had applied his mind to the question to be decided could have arrived at it'

²⁸ *R v Hallstrom ex parte W and R v Gardner ex parte L* [1986] QB 1090.

²⁹ *B v BHB Community Healthcare NHS Trust* [1999] 1 FLR 106.

³⁰ *Ibid.* at 115.

³¹ Mandelstam, M., *Community Care Practice and the Law*, (2009, 4th ed. London, Jessica Kingsley Publishers) p.104.

³² *Council of Civil Service Unions v Minister of State for the Civil Service* [1985] AC 374.

³³ *R v Secretary of State for the Environment, ex parte Nottinghamshire CC* [1986] AC 240.

(*Wednesbury* unreasonableness).³⁴ In cases where human rights are at stake, the courts' assessment of *Wednesbury* unreasonableness has been given even wider scope. They are not confined to interfering only in decisions which are 'outrageous' or *prima facie* 'irrational', but may assess whether the decision maker has maintained a sense of balance and proportionality when making the decision.³⁵ They must subject the decision to 'anxious scrutiny' with regard to the rights of the individual.³⁶ This approach, termed 'heightened-' or 'super-*Wednesbury*', enters the territory of assessing the merits of a case.

Even bolstered by its 'heightened-*Wednesbury*' jurisdiction, judicial review was criticised by the ECtHR in *HL v United Kingdom*.³⁷ The case – which originated in the domestic courts as *R v Bournemouth Community and Mental Health NHS Trust ex parte L*³⁸ – concerned the informal admission to hospital of an adult who lacked capacity. L did not object to his admission (he did not have the capacity to do so), so the professionals involved concluded he did not have to be detained compulsorily under the MHA but could be held informally through the common law doctrine of necessity. Accordingly what followed was a *de facto* detention³⁹ without the safeguards which accompany the formal detention procedure.

The case sheds light on the ECtHR's view on whether judicial review is an adequate safeguarding procedure. The ECtHR held not only that habeas corpus failed to fulfil the requirements of Art.5(4) – unsurprisingly after its finding in *X v United Kingdom* – but that judicial review also fell short of that standard. Although super-*Wednesbury* goes some way towards allowing a merit-based assessment, the standard still fell short as it did not permit independent judicial scrutiny of the medical evidence on the patient's condition.⁴⁰

Furthermore, the requirement that an applicant first must obtain permission from the High Court to institute judicial review proceedings has been criticised on human rights

³⁴ *Council of Civil Service Unions v Minister of State for the Civil Service* [1985] AC 374, at 410, per Lord Diplock, with reference to *Associated Provincial Picture Houses v Wednesbury Corporation* [1948] 1 KB 223.

³⁵ *R (Daly) v Secretary of State for the Home Department* [2001] UKHL 26.

³⁶ *Bugdaycay v Secretary of State for the Home Department* [1987] AC 514.

³⁷ *HL v United Kingdom* (2005) 40 EHRR 32.

³⁸ *R v Bournemouth Community and Mental Health NHS Trust ex parte L* [1999] 1 AC 458.

³⁹ Lord Steyn found that 'the suggestion that L was free to go is a fairy tale.' *Ibid.* at 495.

⁴⁰ *HL v United Kingdom*, at [138].

grounds, a criticism which might also be levied at habeas corpus. *Ashingdane v United Kingdom*⁴¹ concerned an individual's attempt to secure a judicial remedy to enforce his civil rights under mental health legislation. In what Gostin (Legal Director of Mind 1975-82) disparagingly refers to as a 'remarkable case',⁴² the ECtHR held that the requirement to obtain leave to institute proceedings was permissible under the ECHR. Gostin raises a concern that British lawyers are overly ready to conclude 'that persons with mental disabilities are prone to pursuing vexatious litigation'.⁴³ The need to obtain leave exists precisely to prevent vexatious litigators, 'busybodies, cranks and other mischief-makers' from wasting time and money.⁴⁴ A greater respect for mental health patients than that with which Gostin credits British legal professionals is required to ensure judicial review works for patients in this context.

4 Mental Health Review Tribunals

The limitations of habeas corpus and judicial review underline the importance of the Mental Health Review Tribunal (MHRT) in challenging compulsory detention. It has been heralded as a 'safeguard for the liberty of the individual [...] to insure against unjustified detention in hospital',⁴⁵ which unlike habeas corpus and judicial review focuses on the *merits* of a case. A patient detained under s.2 for assessment or s.3 for treatment may apply to the MHRT within, respectively, 14 days or 6 months from the date of his/her admission.⁴⁶ The MHRT has the power to discharge a patient detained under the MHA if it is not satisfied that certain criteria exist.⁴⁷ These criteria reflect the conditions necessary for the initial detention and so include: the patient suffering from a mental disorder of a degree or nature which warrants his/her detention in hospital for assessment/treatment;⁴⁸ that his/her detention is justified in the interests of the health

⁴¹ *Ashingdane v United Kingdom* (1985) 7 EHRR 528.

⁴² Gostin, L., 'Human Rights of Persons with Mental Disabilities', (2000), 23(2) *International Journal of Law and Psychiatry* 125, p.156.

⁴³ *Ibid.*

⁴⁴ *Inland Revenue Commissioners v National Federation of Self-Employed and Small Businesses Ltd* [1982] AC 617, at 653.

⁴⁵ The Aavold Report, *Report on the Review of Procedures for the Discharge and Supervision of Psychiatric Patients Subject to Special Restrictions*, Cm 5191 (1973) HMSO, London, para 35, quoted in Glover-Thomas, N., *Reconstructing Mental Health Law and Policy* (2002, Butterworths), p.52.

⁴⁶ MHA 1983, s.66(1)(a)-(b) and s.66(2)(a)-(b).

⁴⁷ s.72(1).

⁴⁸ s.72(1)(a)(i) and s.72(1)(b)(i).

and safety of the patient or the protection of others;⁴⁹ and (in the case of a patient detained under a section for treatment) that appropriate medical treatment is available.⁵⁰ Members of a MHRT hearing an application must include one legally qualified member, one medically qualified and one qualified in neither field. At least three members must sit to exercise the tribunal's jurisdiction.⁵¹

Tribunals are generally seen as more accessible, cheaper, speedier and benefitting from more specialist expertise than the courts.⁵² They are separate from government, and are thus able fairly to review the enacting of statutes in a position of independence from the legislature.⁵³ The MHRT has been honed over the years to enhance compliance with the ECHR. For example to detain a patient, hospital managers must now show that the criteria for continued detention *are* met, rather than the patient being obliged to show that they are not. Prior to *H*, after which the onus of proof was switched, Bartlett and Sandland note that the rules gave rise to a 'Kafka-esque situation, under which a patient was required to prove that he or she was not mentally disordered before tribunal.'⁵⁴

Thankfully, this has now been rectified. Furthermore, following *X v United Kingdom*, *automatic* review of a patient's detention was instituted, so the patient no longer had actively to apply for it. This brought the provisions of the MHA more into line with Art.5 of the ECHR. The MHRT is now the best placed of all domestic mechanisms to provide the independent judicial scrutiny of the medical evidence demanded by the ECtHR in *HL*.⁵⁵

MHRTs have been criticised for the dynamics between their members. 'Alarming divergences' in members' attitudes and knowledge have been noted in Peay's studies, along with an overly high regard amongst the non-medically trained members for the

⁴⁹ s.72(1)(a)(ii) and s.72(1)(b)(ii).

⁵⁰ s.72(1)(b)(ia).

⁵¹ s.65 and Sch.2 para 1(b).

⁵² Richardson, G., and Genn, H., 'Tribunals in transition: resolution or adjudication?' (2007) *Spr Public Law* 116.

⁵³ The Franks Committee found in 1957 that, rather than being 'appendages of government', tribunals should be 'regarded as machinery provided by Parliament for adjudication rather than as part of the machinery of administration.' *Report of the Committee on Administrative Tribunals and Inquiries*, Cm 218 (1957), para 40, quoted in Richardson and Genn, 'Tribunals in transition' p.116.

⁵⁴ Bartlett and Sandland, *Mental Health Law*, p.498.

⁵⁵ *HL v United Kingdom* (2005) 40 EHRR 32. The MHRT safeguards were not available to the patient in *HL* as he was not detained under the MHA: at [131].

medically trained ones.⁵⁶ The Mental Health Review Tribunal Guide to Members dictates that the medically trained member should refrain from giving an opinion as to discharge in the pre-meeting hearing with other members.⁵⁷ However, the research of Machin and Richardson has found strong opinions of the medical members are frequently conveyed directly or subtly through their lines of questioning.⁵⁸ Although these studies are dated, the difficulty in levelling the playing field of members' influence inevitably remains. Rules cannot prevent one professional holding another professional in particular esteem, and it is very difficult to evidence whether or not this is happening systematically. There is an inherent tension in a supposedly independent judicial body relying on the judgment of members of the very profession whose decisions are being questioned. This has been widely noted.⁵⁹ Machin and Richardson observe that the practice whereby the medically trained member examines the patient before the hearing to gauge his/her condition:

immediately raises difficulties in terms of orthodox legal doctrine. The tribunal doctor who already carries the role of tribunal member and expert is [...] required to become a witness as well.⁶⁰

This is especially problematic if, as seems to be the case, the views of this multi-role member are accorded particular gravity. A mental health patient should be able to utilise a legal mechanism to challenge a medical decision, but the mechanism appears to be heavily influenced by the medical profession.

Conclusion

This article has focused on only a very small part of mental health law.⁶¹ It is of course not the case that the treatment of a patient necessitates a choice between formal admission to hospital or no treatment at all. It is in the sphere of compulsory detention

⁵⁶ Glover-Thomas, *Reconstructing Mental Health Law*, p. 54, in reference to Peay, J., 'Mental Health Review Tribunals – just or efficacious safeguards?', (1981) 5(2) *Law and Human Behaviour* 161.

⁵⁷ Noted in Machin, D. and Richardson, G., 'Judicial review and tribunal decision making: a study of the mental health review tribunal', (2000) *Public Law* 494, p. 499.

⁵⁸ *Ibid. passim*.

⁵⁹ Glover-Thomas, *Reconstructing Mental Health Law*, p.54; Richardson and Genn 'Tribunals in transition' p.136; Bartlett and Sandland, *Mental Health Law*, p.685.

⁶⁰ Machin, D. and Richardson, G., 'Judicial review and tribunal decision making: a study of the mental health review tribunal', p.499.

⁶¹ Very many of those affected by mental health law will not be admitted to hospital. Of those with mental illnesses that are admitted (some 28,200 per year), 26 per cent are detained under the Mental Health Act. (Statistics are from Mind, 'Statistics 4: The Mental Health Act 1983', and relate to 2006-07). The percentage that launch a legal challenge to detention will be lower still.

though that the central tensions of mental health law are in the sharpest focus. Akuffo criticises the ‘limited conception of human rights’ in the West ‘as essentially adherence to procedures, processes and protocols’.⁶² Habeas corpus and judicial review, the purely legal remedies, are almost wholly concerned with procedure. The super-*Wednesbury* standard goes some way to addressing the merits of a case, but according to the ECtHR not far enough. In this respect, the ECtHR seems to share Akuffo’s concern with procedure-based remedies, though perhaps not to the same extent. The danger is that habeas corpus and judicial review only protect the patients for whom the social workers and doctors have not filled out the forms correctly. It would be theoretically possible to detain an individual quite wrongly by following procedure correctly and habeas corpus and judicial review could do nothing to intervene.

It is thus concerning that the mechanism by which a case *can* be judged on its merits – the MHRT – is skewed by the influence of the medical profession. The law should protect the rights of the individual, yet it seems to depend to large extent in this context on the beliefs of doctors. This tension is nothing new. Glover-Thomas charts the oscillation between legalism and medicalism in the history of mental health legislation.⁶³ Justices of the Peace played the pivotal role in detaining patients under the Lunacy Act 1890 whereas the MHA 1959 constituted ‘the high watermark of medical influence over the treatment of psychiatric patients’.⁶⁴ The MHA 1983 (now amended by the MHA 2007, but still largely the basis for current mental health law) displays a ‘new legalism to establish more control over psychiatrists’.⁶⁵ Nevertheless, as an examination of MHRTs illustrates, tensions between the professions remain.

Tensions exist too between human rights absolutists and paternalists. At one end of the scale are those like Akuffo, who cites approvingly Rawls’ *A Theory of Justice*:

Each person possesses an inviolability founded on justice that even the welfare of society as a whole cannot override.⁶⁶

⁶² Akuffo, K., ‘The involuntary detention of persons with mental disorder in England and Wales – A human rights critique’, (2004) 27 *International Journal of Law and Psychiatry* 109, p. 109.

⁶³ Glover-Thomas, *Reconstructing Mental Health Law* pp.1-36.

⁶⁴ *Ibid.* p.27.

⁶⁵ *Ibid.* p.35.

⁶⁶ Akuffo, K., ‘The involuntary detention of persons with mental disorder’ p.109.

At the other sit those, hopefully in the minority today, who share Lord Denning's attitude, voiced in 1957:

It is an unfortunate feature of mental illness that those afflicted by it do not realize the need for their being under the care and control of others. They resent it, much as a small child or a dumb animal resents being given medicine for its own good, and they are apt to turn round and claw and scratch the hand that gives it.⁶⁷

Lord Denning's comparison between a sufferer of a mental illness and a child or wild animal may be offensive to the modern ear, but Akuffo's solution seems unconvincing on a practical level, based on a utopian 'active and mass participatory' attitude towards human rights 'across all of society'.⁶⁸ This ideology, though admirable, does not deal practically with the mental health patient who is acting aggressively in his family home today, threatening to harm him/herself and his/her parents. Akuffo would surely not advocate putting mentally ill individuals through the criminal justice system, yet he criticises detention under the MHA on human rights grounds.

Everyone – doctors, lawyers, human rights activists – has the best interests of the patient at heart, but differing priorities emerge. Giving absolute discretion to any one of these groups will cause unease, fear and/or injustice for others. Balance is key. It seems yet to be achieved in the mechanisms for challenging detention under English mental health law, but must nevertheless be sought tirelessly and in earnest.

⁶⁷ *Richardson v London County Council* [1957] 1 WLR 751, at 760.

⁶⁸ Akuffo, K., 'The involuntary detention of persons with mental disorder', p.132.